The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Cheryl Horne.

DIGEST 153

Proposed law redefines certain terms for purposes of present law relative to assuring portability, availability, and renewability of health insurance coverage, administered in part by the La. Health Plan, as follows:

(1) Deletes Medicare coverage benefits from the definition of those"excepted benefits" not subject to requirements if offered as a separate insurance policy and adds Medicare supplemental health insurance benefits as defined by the federal Social Security Act.

(2) Includes under the definition of "creditable coverage" certain medical assistance coverage provided under federal law.

(3) Changes the definition of "eligible individual" from an individual who elected COBRA continuation or a similar state program to an individual who, if offered the option of continuation of COBRA coverage or a similar state program, elected this coverage.

Proposed law Requires the board of directors of the plan to provide the details of the calculation of each participating insurer's assessment in its plan of operation which is submitted to the commissioner of insurance for his approval. Further authorizes the board, with the approval of the commissioner, to establish, provide for, administer, and contract to provide coverage for a health plan to offer eligible individuals and families the ability to purchase or enroll in a program established under federal law that provides expanded coverage for state high risk pools.

Present law requires the board to establish reasonable reimbursement amounts for health care services and providers determined by the plan to be medically necessary, including but not limited to a list of services specified.

Proposed law instead provides that covered expenses shall be the usual, customary, and reasonable charge, as established by the board, in the locality for the following services when prescribed by a physician and determined by the plan to be medically necessary for the following areas of services specified.

Present law excludes mental and nervous coverage, including alcohol and substance abuse, from these services.

Proposed law eliminates this mental and nervous and alcohol and substance abuse coverage exclusion. However, adds that for the services for diagnosis and treatment of mental and nervous disorders, a covered person may be required to pay up to a 50% coinsurance payment and the plan's payment may not exceed $25,000. Further authorizes the Department of Insurance to conduct a periodic actuarial cost analysis to determine whether the plan's maximum payment for

outpatient services for diagnosis and treatment of mental and nervous disorders should be adjusted.

Present law provides that if the amount charged for services provided by or at the direction of a health care provider exceed the amount payable for covered expenses by the plan, the health care provider may seek amounts payable for covered expenses from the member as allowed under applicable contracts or state and federal laws and regulations.

Proposed law deletes present law.

Present law states that the plan determines the standard risk rate by calculating the average individual standard rate for the five largest insurers offering coverage in the state comparable to the plan coverage.

Proposed law adds that the plan shall make this determination with the assistance of the commissioner.

Present law states that there are standard rates for federally defined eligibles.

Proposed law clarifies that such rates are for federally defined eligible individuals. Additionally provides that initial rates for such individuals shall not be less than 125% and not more than 200% of standard risk rates applicable to individuals.

Present law provides that initial rates for plan coverage provided to nonfederally defined eligible individuals shall not be less than 150% of rates established as applicable for individual standard risks, or the minimum monthly rates as provided for in present law, whichever is greater. Further requires that subsequent rates provided to such individuals shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in present law. Specifies that in no event shall plan rates exceed 200% of rates applicable to individual standard risks or shall rates be lower than 110% of rates applicable to individual standard risks.

Proposed law deletes present law.

Present law allows a six-month pre-existing condition provision to be applied to non-federally qualified individuals.

Proposed law provides no pre-existing condition for federally defined eligible individuals; otherwise retains present law.

Effective upon signature of governor or lapse of time for gubernatorial action.

(Amends R.S. 22:1061(3)(d)(i), 1073(B)(4), 1210(D), (E), and (F), 1213(B) (intro. para.), (F)(3), and (G); adds R.S. 22:1061(4)(k), 1205(C)(6) and (D), and 1213(B)(14); repeals R.S. 22:1213(D)

and (E)(12))